# Abbey & Abbey, Consultants, Inc.

# Medical Reimbursement Newsletter

**A Newsletter for Physicians, Hospital Outpatient & Their Support Staff Addressing Medical Reimbursement Issues**

April 2011– Volume 23 Number 4

**ISSN: 1061-0936**


## APC/APG Update

Watch for the APC update Federal Register for proposed changes for CY2012.

## Ambiguous Guidance from CMS: What to Do!

Ever since the implementation of APCs (Ambulatory Payment Classifications) starting in 2000 there have been significant questions raised that still do not have clear and concise answers. Note that in the April 7, 2000 *Federal Register* CMS also formalized and codified the provider-based rule (PBR). Understanding and interpreting guidance from CMS has become extremely difficult given that CMS is apparently refusing to provide explicit guidance.

Here are four issues among others:

1. **Active Monitoring** – Compliance for coding and billing observation services has been in a state of constant evolution for the past ten years. One of the more recent issues involves subtracting time from observation hours when services are being provided that require active monitoring. What is needed is a precise definition of *active monitoring*. For instance, do routine hydrations and infusions meet the definition of active monitoring? While CMS provides some guidance, it is still difficult to determine if an observation patient receiving hydration involves active monitoring and then that the time for the hydration should be subtracted from the observation hours.
2. **Physician Supervision** – The physician supervision requirement that generally involves the provider-based rule (see 42 CFR §413.65) was quiescent from 2000 until 2008 when physician supervision for on-campus services unexpectedly became an issue. Through 2008 to the present day, the rules involving physician supervision have morphed. Currently, the main concept is that the physician or qualified non-physician practitioner must be immediately available and ready to take over the given therapeutic procedure. For 2011 the requirement that the physician or practitioner has to be on-campus was removed. What is missing is a precise definition of what *immediately available* means. Ostensibly, this would involve a proximity metric or a time metric. You can establish your own metrics if desired such as the supervising physician must be within 50 yards or be available within 5 minutes. There is also the issue that you should be able to affirmatively establish who the supervising physician/practitioner was for a given location and time period.
3. **Related Services Under the 3-Day Pre-Admission Window** – For the pre-admission window the world changed on June 25, 2010 when legislation was passed that generalized the concept of what constitutes related services under the pre-admission window. This is a process in which certain related services that are provided on an outpatient basis must be bundled into the inpatient billing. Prior to the change in the Social Security Act, there was a very precise definition that the services in the pre-admission window had to be such that the primary diagnosis matched exactly the principal diagnosis occasioning the admission. On June 25th the guidance simply involves being related, and hospitals now bear the burden of determining what is related and being able to defend themselves relative to their policies and procedures in this area.
4. **Technical Component E/M Mappings** – The mappings of resources utilized into the various E/M levels for technical component billing is an example of a long-term issue with significant ambiguity. This issue started with the implementation of APCs (Ambulatory Payment Classifications) back in 2000. At that time hospitals expected that CMS would issue national guidelines so that compliance could be judged easily by everyone. The simple fact is that eleven years later there are no national guidelines, and there seems little indication of CMS issuing national guidelines. Thus, every hospital in the country has developed their own mappings with the understanding that there is no way to verify that any of these mappings are compliant.

If we start looking at common features for specific trends in guidance from CMS, at least for these examples, there are some concerns.

- ***Increasing ambiguity in guidance is quite clear***. Key terminology is used without precise definitions. This is often true even if healthcare providers ask CMS to provide clear, precise guidance that can be audited and also operationalized for proper billing.
- ***The burden of proof or the ability to establish compliance is shifted from precise guidance over to the healthcare providers***. Thus, hospitals and other healthcare providers must make policy decisions and establish procedures so that documentation is routinely maintained to establish compliance.
- These ***trends seem almost as a ploy for the RACs*** and other governmental auditors to come in years later and determine the hospitals were not compliant, after-the-fact, based on refined or *clarifying* guidance.

The last concern involves clarifying guidance. This process of clarifying guidance versus changed guidance became a significant topic of discussion relative to the physician supervision requirements. Why? If the guidance being provided, possibly years after the fact, is clarifying, then there is no change in guidance, just a *refinement* in the guidance. If the guidance involves a *change*, then Section 912 of the MMA (Medicare Modernization Act 2003) comes into play because changed guidance cannot be retroactively applied. If it is simply clarifying guidance, then, ostensibly, the guidance can be applied retroactively.

Of course, this fits very nicely into the whole RAC process. If the RACs pursue an issue, they must have some sort of guidelines, and/or CMS must issue clarifying guidance. Based on the experience with the physician supervision rule issue, CMS seems willing to go to great lengths to argue that significant shifts in guidance are simply clarifications.

Operationally, the big question is: What should hospitals do to address ambiguous guidance? Two immediate steps are:

1. Carefully craft policies and procedures to address the areas where there is ambiguous guidance, and
2. Continue to press CMS for additional guidance that is clear, concise and specific.

While coding, billing and chargemaster personnel are constantly drafting and revising policies and procedures, decisions must be made relative to these sensitive compliance issues. Often there is a continuum of approaches that can be taken that vary from the conservative to the more aggressive. Obviously, taking an aggressive or liberal compliance perspective increases the compliance risk of audits and recoupments in the future, but conservative approaches tend to reduce reimbursement. Thus, hospital personnel will often look for a reasonable approach that delimits compliance issues and yet allows for proper reimbursement.

Take the question of *related services* under the 3-Day Pre-Admission Window. A conservative approach would simply involve bundling all services, diagnostic or therapeutic, into the inpatient billing. Without a doubt this would mean that some unrelated services would be bundled thus reducing payment.

On the other hand some sort of a diagnosis code test could be adopted. This process is similar to the diagnostic code tests that CMS used prior to June 25, 2010. For instance, a hospital might set a requirement that the first three digits of the primary outpatient diagnosis must match the first three digits of the principal diagnosis for the inpatient admission.[1] This would be for therapeutic services because all the diagnostic services would be billed through the inpatient billing.

The second step is to continue to request that CMS provide definitive guidance, or at least hospitals should be held-harmless when there appears purposeful ambiguity. In theory, CMS and its administrative contractors are to provide answers to inquiries in a ***clear, concise, and accurate manner***. See Section 921 of the MMA 2003.

## New Codes for CVIR – Part 2

For 2011 CPT has dramatically modified the coding structures in the cardiovascular interventional radiology (CVIR) area. While coding for heart catheterizations has completely changed, the coding structure is fairly straightforward. The changes on the vascular side, that is, non-coronary side, has been split into two parts:

- Subinguinal – Lower Extremities, and
- Infrainguinal – Upper Body.

The new coding structures will require significant study and analysis in order to properly code and bill. There are two aspects of particular interest to auditors:

1. Correctly following the coding guidelines, and
2. Utilizing a coding process that results in correct coding and billing.

[1] This diagnostic test was proposed by the Healthcare Financial Management Association (HFMA) in a letter dated December 9, 2010 to CMS.

In this second article we will look at the subinguinal vascular catheterization codes and associated coding guidance from CPT.

One of the most fundamental and perplexing question for CVIR is: What is a vessel? This may sound almost trite. In actual application for coding and billing, particularly for therapeutic services, this question is very real because certain CPT codes as described as 'each vessel' or 'each additional vessel'. Thus knowing when one vessel begins and another one ends is significant.

For the lower extremities, CPT is now officially defining three different territories for coding and billing purposes.

- **Iliac Vascular Territory** → Common Iliac, Internal Iliac & External Iliac (Base + Add-Ons)
- **Femoral/Popliteal Vascular Territory** → Single Vessel for Coding
- **Tibial/Peroneal Territory** → Anterior Tibial, Posterior Tibial & Peroneal (Base + Add-Ons)

For both coding staff and auditing staff we now have definitive guidance as to the three territories and the vessels within the given territory. For the iliac and tibial/peroneal territories there are multiple vessels (three each) while for the femoral/popliteal territory all the vessels are considered a single vessel for coding and billing purposes.

For the iliac vascular territory we have the following sequence of codes:

- 37220 – Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty
  - 37222 – Add-On Code for additional vessels
- 37221 - Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; With transluminal stent placement(s), includes angioplasty within same vessel when performed
  - 37223 – Add-On Code for additional vessels

Note that these codes involve both open and percutaneous services. There are add-on codes for additional vessel for which angioplasties or stenting are performed. When you look at this sequence, you will realize that something is missing. What is missing are the atherectomies. Where did they go?

For some reason CPT decided to move the iliac atherectomies into the new (and temporary) Category III code sequence: 0234T-0238T. In this case 0238T is for the iliac artery, each vessel. This exclusion creates a coding challenge in that the 0238T code does not include the accessing and selective catheterization of vessels. The 37220-37235 sequence includes the accessing and selective catheterization of vessels.

For the femoral/popliteal arteries there is only one vessel for coding purposes so there is no need for add-on codes.

- 37224 – Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s) unilateral; with transluminal angioplasty
- 37225 - with atherectomies, includes angioplasty within the same vessel, when performed
- 37226 - with transluminal stent placement(s), includes angioplasty within the same vessel, when performed
- 37227 - with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed

Within this sequence you can see that these sequences are hierarchically inclusive. For the femoral/popliteal territory only one code (per leg) will be used from the sequence. For instance, if an atherectomy is performed and then there are also stent(s) placed, then 37227 would be used. 37227 would also include angioplasty if performed as well.

For the tibial/peroneal territory there are multiple vessels for coding purposes, and we do have a full sequence of codes relative to the abbreviated sequence for the iliac territory.

- 37228 – Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal angioplasty
  - 37232 – Add-On code for additional vessels (Use with 37228-37231)
- 37229 - Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel when performed
  - 37233 – Add-On code for additional vessels (Use with 37229-37231)
- 37230 - Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed
  - 37234 – Add-On code for additional vessels (Use with 37230, 37231)
- 37231 - Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel when performed

- 37235 – Add-On code for additional vessels (Use with 37231)

For the tibial/peroneal territory we have a full, hierarchically inclusive set of codes along with add-on codes for additional vessels within the territory. Note that the add-on codes are generally available for the various therapeutic services. Thus, if there are stent(s) placed in the peroneal, CPT 37231 would be used. If there is also an angioplasty of the anterior tibial then CPT 37232 would also be used as an add-on code.

CPT contains ***extensive coding guidelines*** that go along with these new sequences of codes. These guidelines must be studied with great care. CPT is now also referencing laser atherectomies, which is a relatively new technology.

- ✓ *Codes 37220-37235 are to be used to describe lower extremity endovascular revascularization services performed for occlusive disease.*
- ✓ *These lower extremity codes are built on* ***progressive hierarchies*** *with more intensive services inclusive of lesser intensive services.*
- ✓ *The code inclusive of all of the services provided for that vessel should be reported (i.e., use the code inclusive of the most intensive services provided).*
- ✓ *Only one code from this family (37220-37235) should be reported* ***for each lower extremity vessel treated****.*
- ✓ *These lower extremity endovascular revascularization codes all* ***include the work of*** *accessing and selectively catheterizing the vessel, traversing the lesion, radiological supervision and interpretation directly related to the intervention()s) performed, embolic protection, if used, closure of arteriotomy by any method, and* ***imaging performed to document completion of the interventions*** *in addition to the intervention(s) performed.*
- ✓ *When treating multiple territories in the same leg, one primary lower extremity revascularization code is used for each territory treated.*
- ✓ *When second or third vessel(s) are treated in the iliac and/or tibial/peroneal territories, add-on code(s) are used to report the additional service(s).*
- ✓ *When more than one stent is placed in the same vessel, the code should be reported only once.*
- ✓ *If a lesion extends across the margins of one vessel vascular territory into another, but can be opened with a single therapy, this interventional should be reported with a single code despite treating more than one vessel and/or vascular territory.*
- ✓ *When the same territor(ies) of both legs are treated in the same session, modifiers may be required to describe the interventions. Use modifier 59 to denote that different legs are being treated.*

Now even with this synopsis of guidance listed above, there are some important coding concepts.

i. ***Follow-up angiographies*** are included as a part of the services. This is a question that has received much attention over the years and now CPT has made this definitive.
ii. ***Catheterization services*** are included in the therapeutic services. Thus, only the catheterizations involving purely diagnostic services would be separately reported. Since APCs do not pay separately for these catheterization codes, this is purely a coding issue as opposed to a payment issue.
iii. ***Closure of the arteriotomy*** is included in these codes. Thus the placement of vascular plugs and/or other closure services is included. See HCPCS codes G0269 and C1760 that are discussed in the first part of this article.
iv. To distinguish the two legs, CPT is indicating that the ***"-59" modifier*** should be used. This is strange because the "-59" modifier is the modifier of last resort. In this case, the use of "-LT" for left and "-RT" for right would appear more appropriate.

## Questions from Our Readers

**Question: We are working on writing policies and procedures for proper coding for discontinued procedures. We sometimes have procedures that require imaging services in order to perform a surgical procedure. Occasionally, a patient will be brought to the procedure room and then the imaging indicates that the procedure cannot be performed. Are we allowed to at least charge for the imaging service?**

This question generally falls under the heading of discontinued procedures. In certain circumstances the proper way to code and bill can become complex, and hospitals should carefully craft policies and procedures.

For this specific question, the imaging that is involved may be a part of the surgical procedure and thus is not generally coded separately. On the other hand the imaging guidance and the surgery may be separately coded, billed and even separately paid. The procedure that was discontinued may involve anesthesia so that the "-73" and "-74" modifiers must be considered. Note that over a period of years, CMS finally indicated that conscious sedation is anesthesia at least for coding and billing purposes.

As a very general rule, when there is a planned procedure and the procedure is actually commenced but discontinued before completion, then the procedure will be coded and either a "-74" or "-52" modifier will be used depending upon whether anesthesia is involved. Keep in mind that this is a general approach for which there may be exceptions.

A complicating factor may occur with interventional procedures for which both the radiology and surgical component are coded. If such a procedure is planned, the patient is brought to surgery and the procedure is discontinued even before starting, then the procedure should be coded with the "-73" modifier. Ostensibly, both the radiology and surgery will be so coded although explicit guidance in this area is less than precise.

For the above situation, if the procedure is started and then discontinued, the "-74" modifier would be used on both the radiology and surgical codes. This particular issue has arisen in a number of settings including cardiovascular interventional radiology. If multiple procedures were planned, then the first planned procedure should be coded.

In developing a policy and associated procedures consider the following approach.

1. If the patient presents for a procedure and a nursing assessment contraindicates the procedure, then a technical component E/M would be coded.
2. If the patient presents for a planned procedure not requiring anesthesia and the procedure is discontinued, then use the "-52" modifier.
3. If the patient presents for a planned procedure and anesthesia (including conscious sedation) is required, then:
    a. If the patient is brought to the operating room and anesthesia is not administered, then the planned procedure is coded along with the "-73" modifier.
    b. If the patient is brought to the operating room, and anesthesia is administered and the procedure is terminated either before starting or before being completed, then code the planned procedure and/or commenced procedure and use the "-74" modifier.

This approach should be considered only as a general guideline. There will be challenges with applying any approach. For instance, with discontinued interventional procedures, the surgical code may require the -73/-74 modifier and the radiological code the -52 modifier.

## Current Workshop Offerings

*Editor's Note: The following lists a sampling of our publicly available workshops. A link for a complete listing can be found at:*
*www.aaciweb.com/JantoDecember2011EdCal.htm*

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On-site, teleconferences and Webinars are being scheduled for 2011. Contact Dr. Abbey at 515-232-6420 or e-mail at DrAbbey@aaciweb.com for information.

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A variety of Webinars and Teleconferences are being sponsored by different organizations including the Georgia Hospital Association, Ohio Hospital Association, Florida Hospital Association, Instruct-Online, Texas Hospital Association, Colorado Hospital Association, Hospital Association of Pennsylvania, and the Eli Research Group. Please visit our main website listed above for the calendar of presentations for CY2010 and planned workshops for CY2011.

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The Georgia Hospital Association is sponsoring a series of Webinars each month. For more information, contact Carol Hughes, Director of Distance Learning at (770) 249-4541 or CHughes@gha.org. The webinar scheduled for May 10th "***The -59 Modifier and the NCCI Edits***" that will run from 9:30 a.m. to 11:00 a.m. EST.

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Dr. Abbey's latest book:
"***The Medicare Recovery Audit Contractor Program: A Survival Guide for Healthcare Providers***" is now available for purchase. This is a companion volume to "***Compliance for Coding, Billing & Reimbursement: A Systematic Approach to Developing a Comprehensive Program***", 2nd Edition.

Both of these books are published by CRC Press of the Taylor & Francis Group. A 15% discount is available for subscribers to this Newsletter. For ordering information contact Chris Smith through Duane@aaciweb.com.

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Also, Dr. Abbey has finished the second book in a series of books on payment systems. The first book is: "***Healthcare Payment Systems: An Introduction***". The second book in the series addresses fee schedule payment systems and is now available. The third and fourth books in this series are devoted to prospective payment systems and other payment systems. Both are currently in development.

This series is being published by CRC Press of the Taylor & Francis Group. Contact information is provided below. Discounts for subscribers of this Newsletter are available.

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## ****** ACTIVITIES & EVENTS ******

**Schedule your Compliance Review for you hospital and associated medical staff now. A proactive stance can assist hospitals and physicians with both compliance and revenue enhancement. These reviews also assist in preparing for the RACs.**

**Worried about the RAC Audits? Schedule a special audit study to assist your hospital in preparing for RAC audits. Please contact Chris Smith or Mary J. Wall at Abbey & Abbey, Consultants, Inc., for further information. Call 515-232-6420 or 515-292-8650. E-Mail: Chris@aaciweb.com.**

**Need an Outpatient Coding and Billing review? Charge Master Review? Concerned about maintaining coding billing and reimbursement compliance? Contact Mary Wall or Chris Smith at 515-232-6420 or 515-292-8650 for more information and scheduling. E-Mail: Duane@aaciweb.com**